TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS HEALTH DBA INJURY 1 DALLAS

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-16-1021-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were provided and the claims were denied per EOB precertification/ authorization exceeded. CPT code 90837 was preauthorized, #10933879. Please refer to the attached authorization letter for further review. In summary, it is our position that Sedgwick CMS has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered to [injured employee]."

Amount in Dispute: $399.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 21, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2015 and March 31, 2015	90837 X 2	$399.00	$399.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the procedure for Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 198 – Precertification/authorization exceeded

Issues

1. Did the requestor submit documentation to support that CPT Code 90837 rendered on March 24, 2015 and March 31, 2015 was preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 90837 rendered on March 24, 2015 and March 31, 2015. The insurance carrier denied the disputed services with denial/reduction code "198 –Precertification/ authorization exceeded."

   28 Texas Administrative Code §134.600 (p)(7) states in pertinent part, "Non-emergency health care requiring preauthorization includes: (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur: (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   Review of the submitted documentation finds that preauthorization was obtained for "Individual Psychotherapy 1 weeks x 8 weeks" with reference number "10933879," for dates of service starting February 9, 2015, and ending June 30, 2015. The Division finds that the requestor rendered CPT Code 90837 between the starting date and the ending date. As a result, the insurance carrier's denial reason is not supported and the disputed services are therefore reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year."

   Per 28 Texas Administrative Code §134.203 "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT code 90837 per hour is $199.50 x 2 dates of service equals $399.00. The requestor seeks $399.00, therefore this amount is recommended.

   The Division finds that the requestor is entitled to reimbursement for CPT code 90837 rendered on March 24, 2015 and March 31, 2015 in the amount of $399.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $399.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $399.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.